Exhibit B

Hospital Records

HCA ROCKFORD CENTER

DISCHARGE SUMMARY

PATIENT: Barry Croft DATE: 05/16/90

ADMITTED: 01/24/90 DISCHARGE DATE: 02/24/90

MEDICAL RECORD #6856 PHYSICIAN: Dr. Desai

ADMITTING DIAGNOSIS: Adjustment disorder with mixed features of emotions and conduct. Rule out bipolar disorder. Passive personality disorder.

AXIS I. 1. Adjustment disorder with mixed features of emotions and conduct.
2. Rule out bipolar disorder.

AXIS II. Passive personality disorder.

AXIS III. Stressors: Interfamily conflicts.

AXIS IV. Maximum functioning at school last year 2-3
Maximum functioning at home 3 to 4.

DISCHARGE DIAGNOSIS: Adjustment disorder with mixed features of emotions and conduct disorder.

ALLERGIES: None

CURRENT MEDICATIONS: None

REASON FOR ADMISSION: Angry outbursts, acting out behavior, aggressive behavior.

REASON FOR INADEQUACY OF OUTPATIENT TREATMENT AT THIS TIME: Patient was unable to control his behavior.

JUSTIFICATION FOR ADMISSION: Deteriorating psychotic condition over the last three weeks.

HISTORY OF PRESENT ILLNESS: This 14 year old, white, single male, was admitted after he was evaluated on an outpatient basis. Two days prior to admission patient got extremely angry, started cussing, hollering, shouting, throwing things around, broke furniture and went on a rampage for about two hours until he was calmed down by his aunt. Patient stated he got tired of being treated unfairly and he did not know what happened to him but he got angry and could not control it.

Patient states that over the last two to three weeks he has been getting upset easily, he is unable to sleep, he is experiencing primary and secondary insomnia. He is experiencing nightmares and night terrors and wakes up with dreams of shock. Patient states that over the period of the last two to three weeks he finds his feet cold. He finds tremendous mood swings. At times he feels sleepy, other times he feels angry and other times feels normal. He states he cannot find any reason for these mood swings. Patient denies any major changes in his life over the last two months but states that he feels that his family treats him unfairly.

Patient lives with his father, younger sister, grandmother, grandfather and aunt. Patient states that his mother, who is married again, he does not see her as often as he would like to see her. He is not allowed in the mother's house because the mother lives with her mother and grandparents will not allow him there. Patient states that where he lives his grandparents treats his sister better than him. His father has no time for the children.

Patient gives a history of poor school functioning over the last few years. He states he has no difficulty in learning, but he is lazy and finds it difficult to finish his work. Patient also states that he has been cited many times for not being able to sit still in the class.

HISTORY OF PREVIOUS PSYCHIATRIC ILLNESS: None.

MEDICAL HISTORY: Patient denies any major medical problems, denies drug or alcohol abuse. There is a family history of mother having a bipular illness who is being treated with Lithium.

MENTAL STATUS EXAMINATION: Patient is very casual, passively cooperative, speech is normal, affect anxious, mood depressed. There is no hallucinations, no delusional ideation. Patient denies any death wishes or suicidal ideation. He seems to be preoccupied with his feeling of not being wanted. His thought processes are productive, continuous and there is no language impairment. He has poor abstract thinking. He seems to have a good fund of information. He seems to have average intelligence. His concentration is good. He is able to do serial 7's forwards and backwards without much problem. He is oriented to time, place and person. His memory of remote and recent past is okay. His immediate retention and recall is okay. He seems to have very poor impulse control, very poor judgement and very poor insight into his problems, although he seems very reliable informant.

PHYSICAL STATUS: Physical examination was performed by Dr. Kline whose impression was no major medical problem, has depression. Please see his report for details.

PSYCHOLOGICAL EVALUATION: Psychological Evaluation was performed, please see report for details. Recommendations were to continue family therapy, intensive individual therapy, continue hospitalization and use of medication to control some of the behavior.

LABORATORY DATA: SMA-12 within normal limits except inorganic phosphorus 5.3, BUN creatinine ratio 23.8, triglycerides 120, cholesterol 167. CBC within normal limits except platelet count of 130, urinalysis within normal limits. Drug evaluation was negative.

HOSPITAL COURSE: After being admitted in the hospital, patient was placed on prn Tylenol and close observation, which was subsequently discontinued. Patient was placed on Desyrel 50mg one at bedtime, which was increased to 75mg at bedtime. Patient continued to exhibit difficult behavior, Desyrel was discontinued and patient was placed on Tegretol 200mg twice a day. Patient started to experience some side effects and Tegretol was discontinued and placed back on Desyrel 50mg at bedtime, which was again discontinued and patient was placed on Triavil 2-10 one at bedtime, which was increased to Triavil 4-10 one at bedtime and Trilafon 2mg was added in the morning, which was changed to Triavil 2-10 one in the morning and continue Triavil 4-10 at bedtime and patient was discharged on this medication.

Also during this period of the hospitalization, patient was treated with individual therapy, group therapy, activity therapy, occupational therapy. During the therapy sessions, major focus of individual therapy was help patient gain insight into his problem and take responsibility for behavior, helping him understand his depression and angry outbursts, and working with his low self-esteem. Patient remained anxious and at nervous and talked about being afraid of "things" at his window and having a difficult time dealing with his mother, who is overbearing at times.

During the latter part, patient was more compliant with unit policy and active participate in unit activities and started to make some improvement. Patient started to show some inappropriate behavior, some silliness and acting out behavior. Medication was changed to Triavil and he started to make some improvement with the Triavil.

DISCHARGE SUMMARY BARRY CROFT

Considering the improvement, arrangements were made for discharge.

CONDITION ON DISCHARGE: Improved.

DISCHARGE RECOMMENDATIONS: Patient was given the prescription of Triavil 2-10 one in the morning, two at bedtime. Arrangements were made for patient to be seen by family therapist in Newark area.

PRAFUL C. DESAI, M.D.

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HCA ROCKFORD CENTER
DISCHARGE SUMMARY

PATIENT: Barry Croft
MEDICAL RECORD #: [redacted]
DATE OF BIRTH: [redacted]/75
DATE OF ADMISSION: 4/19/93
PHYSICIAN: Dr. Bauchwitz

ADMITTING DIAGNOSIS:

AXIS I. Adjustment disorder with mixed emotional features
Rule out affective disorder, bipolar

AXIS II. Personality disorder, NOS

AXIS III. Asthma

AXIS IV. Stressors: four

AXIS V. GAF: last year, 50, present, 40

DISCHARGE DIAGNOSIS:

AXIS I. Adjustment disorder with mixed emotional features

AXIS II. Personality disorder, NOS

AXIS III. Asthma

AXIS IV. Stressors: four

AXIS V. GAF: last year, 50, present, 40

HISTORY OF PRESENT ILLNESS: The history is given by Barry himself who is a 17 year old boy that is readmitted to the Rockford Center for the 2nd time. The last admission was in May of 1990. He apparently has had periods of disruptive behavior, not participating well in school and not attending classes. Recently, the day prior to admission, he had a fight with his girlfriend and in the process of solving the problem with her, he took several aspirins. However, he denies suicide and states "I am took conceded to harm myself." He states that he took three aspirins earlier and later on, another three aspirins. The reason was that he had a fight with the boy who was messing around with his girlfriend. They had a very physical fight and he got scratches on his face by this boy and also hit in the head. Later on, he developed headache and took aspirins to solve the problem. Patient has dropped out of his school because he has been failing, despite the fact that in the past, he was a very good student. He is planning to attend summer school if he passes the 11th grade. He has been dating off and on for the last four years this present girl. According to Barry, this weekend, she got drunk, passed out and his boy friend tried to mess around with her. He feels that he and his girlfriend enjoy each

other very much and they like to fight with each other. At all times, he denied wanting to kill himself.

MEDICAL HISTORY: Patient denies any history, except asthma and he has had no surgeries. His mother has been diagnosed with affective disorder, bipolar and is treated with Lithium Carbonate.

DRUG AND ALCOHOL HISTORY: Patient denied.

SOCIAL SITUATION: Patient lives with his mother. He describes his mother as very supportive and he warts to return home to his family.

PERSONAL/FAMILY HISTORY: Parents are divorced. He lives with his mother who has a bipolar disorder and is treated with Lithium Carbonate. He has two sisters and two stepbrothers. Mother works, but is presently on leave. He describes his childhood as okay. "I was a happy kid." He denies being self-destructive. He works at McDonald's and in his free time, he sees his girlfriend and he likes this.

MENTAL STATUS: At the time of admission, patient was neat in appearance with very short dark hair and a mustache as well as a small beard. He has fair eye contact and is cooperative during the interview. There is no evidence of psychomotor retardation or unusual gait. Speech is spontaneous, however, he appears preoccupied with the fact that he is here and when he will be leaving. Mood is despondent. Affect is bland. Patient denies delusions or hallucinations. None were elicited with no evidence of depersonalization or blocking of thought. The thoughts are spontaneous with no evidence of flight of ideas or language impairment. No ideas of reference. Patient appeared to be functioning at a normal level of intelligence. Concentration seems to be poor as of this moment, but he was able to subtract 7 from 100. He is oriented to time, place, and person. Memory is intact. He is able to remember past events and three words in five minutes. Impulse control is poor. Patient appears to have a great deal of anger repressed. Judgement and insight is very poor. Reliability is questionable.

MEDICAL EVALUATION: Was uneventful.

LABORATORY TESTS: The inorganic phosphorus was mildly elevated at 4.8. Uric acid was mildly elevated at 9.2. There was a drug screen, which was negative and the remaining lab work was within normal

Barry Croft
6586/2

limits.

HOSPITAL COURSE: The patient participated in the adolescent program very well. He was cooperative, despite disliking very much being in the hospital. He created no problems. He participated well in the therapies. He also attended family meetings and it was decided then that the patient was no longer suicidal. The crisis was over and he was discharged and referred for follow-up at In-roads.

CONDITION ON DISCHARGE: Improved.

Maria Helena Bauchwitz, M.D.

MHB:lc
DD:5/25/93
DT:5/27/93